POLICIES AND PROCEDURES **State of Tennessee Department of Intellectual and Developmental Disabilities**	**Policy #: 80.4.7**	
Policy Type: Community	**Effective Date: June 1, 2012**	
Approved by: **Commissioner**	**Supersedes: N/A** **Last Review or Revision: May 31, 2012**	
Subject: COMMUNITY TRANSITION POLICY		

I. **AUTHORITY:** Tennessee Code Annotated, Section 4-3-2701; Tennessee Code Annotated, Section 4-3-2708; Tennessee Code Annotated, Section 33-1-201; Tennessee Code Annotated, Section 33-3-103.

II. **PURPOSE:** The purpose of this policy is to clarify the process to transition from one service provider to another or from one residential site to another for people enrolled in any Department of Intellectual and Developmental Disabilities (DIDD) services. This policy will also clarify the responsibilities of all contracted providers concerning community transitions and the ethics of recruiting waiver enrollees.

III. **APPLICATION:** This policy applies to all DIDD staff, support coordination agencies, and contracted providers who may be involved in any service transition for people enrolled in DIDD services.

IV. **DEFINITIONS:**

A. **Case Manager** shall mean an individual who assists the person in gaining access to needed Self-Determination Waiver and other Medicaid State Plan services as well as other needed services regardless of funding source; develops the initial interim Individual Support Plan and facilitates the development of the Individual Support Plan; monitors the person's needs and the provision of services included in the Individual Support Plan; monitors the person's budget, and authorizes alternative back-up services for the person, if necessary.

B. **Circle of Support (COS)** shall mean a group of people who meet together on a regular basis to help a person-supported plan for and accomplish his/her personal outcomes and actions. The person supported is the focus or the center of the COS. At a minimum, this may include the person supported, his/her family member(s) and/or conservator(s), Independent Support Coordinator, Case Manager, and the providers of any supports and services that the person receives. Friends, advocates, and other non-paid supports are included at the invitation of the person.

C. **Community Transitions** shall mean the movement of a person supported from one community service provider to another community service provider, from one residential setting to another residential setting, or from one grand region to another grand region.

D. **Community Transition Coordinator (CTC)** shall mean the Regional Office staff person who oversees the community transition process and ensures that transitions are implemented consistently and according to this policy.

E. **Home and Community Based Services (HCBS) Waiver or Waiver** shall mean a waiver program approved for Tennessee by the Centers of Medicare and Medicaid Services to provide services to a specified number of Medicaid eligible individuals who have an intellectual disability (e.g. mental retardation) and who meet criteria of Medicaid reimbursement of care in an Intermediate Care Facility for the Intellectually Disabled. The Tennessee HCBS waivers operated by the Department of Intellectual and Developmental Disabilities (DIDD) include:

Home and Community-Based Services Waiver for the Mentally Retarded and Developmentally Disabled (#0128.R04.01) and any amendments thereto;

Home and Community-Based Services Waiver for Persons with Mental Retardation (#0357.R02.01) and any amendments thereto; and

Self-Determination Waiver (#0427.R01.03) and any amendments thereto.

F. **Exploitation** shall mean actions included but not limited to deliberate misplacement, misappropriation, or wrongful temporary or permanent use of a person's belongings or money with or without consent. DIDD also considers it exploitation to illegally or improperly use a person or a person's resources for another's profit or advantage.

G. **Independent Support Coordinator** shall mean the person responsible for developing the Individual Support Plan and participating in the development of, monitoring and assuring implementation of the Individual Support Plan; who provides Support Coordination services to the person, and who meets the qualifications for the Support Coordinator as specified in the HCBS Waiver for Persons with Intellectual Disability.

H. **Individual Support Plan (ISP)** shall mean Tennessee's format for the federally required plan of care. The ISP is a person-centered document that provides an individualized, comprehensive description of the person as well as guidance for achieving outcomes that are important to the person in achieving a good quality of life in the setting in which they reside. The ISP clearly describes the needs of the person and the services and supports required to meet those needs. The ISP also serves as the vehicle for justifying the person's need for services so that services can be authorized by the DIDD Regional Offices.

I. **Person Centered Planning** shall mean the process which focuses on a person in terms of who they are, what they want in life, and how their desired outcomes may be accomplished. Based on the values of human rights, inter-dependence, social inclusion, and responsible choice, this process discovers the person's gifts, skills and capacities while balancing what is important to and important for the person now and in the future.

J. **Recruitment** shall mean soliciting persons receiving services within the DIDD provider network for business purposes. It includes directly soliciting, contacting, visiting, or otherwise approaching persons or their legal representatives for the purpose of suggesting, advising, urging, or coercing the person or legal representatives to change providers for the intended purpose of increasing the provider's clientele base and business revenue. Employees of DIDD or DIDD service providers may not use the information that is learned or obtained during his/her employment in a subsequent employment situation to directly and explicitly solicit approach or recruit a person to change from one provider to another provider.

V. **POLICY:** This policy outlines a person-centered planning process for transitions of people supported from one DIDD service provider to another, from one residential home to another or from one grand region to another. This process requires the wishes and desires of the person supported be considered by the COS and incorporated into the planning process. The person and legal representative, if applicable, in conjunction with the COS shall determine if the proposed transition is in the person's best interests and if not, provide justification for pursuing the transition over objections.

VI. **PROCEDURES:**

A. **General Guidelines:** Transition from any service provider initiated by the Person, Circle of Support (COS) or Conservator:

1. Any person enrolled in DIDD services has the right to choose service provision from all available and qualified providers in the DIDD provider network.

2. The Independent Support Coordinator (ISC) or Case Manager (CM) of the person supported is responsible for facilitating the transition, completing the transition form, compiling documents to be included in the transition packet, and forwarding the entire packet to the respective DIDD Regional Office CTC.

3. Any change in provider initiated by the person and/or legal representative must:

   a. Be in the best interest of the person.

   b. Have the agreement of the person supported or document the reason the transition is being pursued without such agreement.

4. If a person in services wishes to transition from one provider to another, and makes this desire known, regardless of reason, the COS has the responsibility to pursue this request.

5. A member of the COS shall inform the person of the outcome of that request. If the person is not able to transition to the chosen provider, alternatives need to be offered.

6. If possible, the issue causing the person's dissatisfaction shall be resolved to the person's satisfaction. However, if there is no resolution to the satisfaction of the person, the legal representative, if applicable, and COS shall continue to investigate alternatives or modifications of current supports to address the person's concerns.

7. The person supported must be included in and informed of any decision concerning where or with whom he/she lives and what services are received. This choice is to be provided even if the person has a legal conservator that typically makes those decisions.

    a. If the person expresses disagreement with a proposed transition, the transition plan must state the reasons for the disagreement and the reason the transition is being pursued without that agreement.

    b. Conservatorship papers may be requested and reviewed by the Regional Office Community Transition Coordinator (CTC). This review is to ensure that the conservator has the legal authority to pursue the transition regardless of the person's wishes.

    c. If there is disagreement among the COS members about the appropriateness of a proposed transition, any member of the COS may contact the DIDD Regional Director or Complaints Coordinator for conflict resolution or mediation.

8. Recruitment of individuals for providers benefit is **not acceptable.** If recruitment is suspected, any member of the COS is encouraged to contact the DIDD Regional Office or Complaints Coordinators prior to the transition meetings for assessment and intervention as needed.

    a. A meeting shall be held with the person, family, conservator, and the current service provider to discuss and attempt to resolve any concerns regarding current services. If these concerns cannot be resolved, the reasons must be thoroughly documented and submitted to the Regional Office as part of the transition packet.

    b. If the Regional Office determines the transition does not benefit the person, the transition plan will be denied.

    c. In addition to the possible denial of the transition, any suspected exploitation will be referred to the DIDD Investigation Unit to determine if exploitation of a person has occurred.

B. **Inter-agency transitions initiated by person supported or conservator**

1. Both the sending and receiving agency shall be involved in all transition planning and have representatives present at all transition meetings

2. The Transition Planning Form shall document how this transition will better meet the needs of the person supported.

3. The transition packet shall be submitted to the Regional Office at least fourteen (14) calendar days in advance of the projected transition date and shall include at a minimum:

    a. An amended ISP, including the amended Section C with the name of the service providers, and the amount, frequency and duration of services.

    b. Transition Planning Form

    c. Recommendations for staff cross training, if applicable.

4. Regional Office staff shall review the ISP in accordance with DIDD service authorization protocols and shall follow established procedures for approval or denial of service requests as well as issue written notice of the decision.

5. A copy of the person's complete comprehensive record (including applicable releases of information) must be transferred to the receiving agency no later than the date of the transition in accordance with Section A.19 of the Provider Agreement.

6. If the person supported or legal representative declines participating in the transition meetings, the Regional Office will be contacted for assistance with resolving any issues.

C. **Changes initiated by the current service provider:** If a service provider has determined that services will be discontinued for a person supported, the provider shall comply with Section A. 19 of the Provider Agreement between the State of Tennessee Department of Intellectual and Developmental Disabilities and the Bureau of TennCare (Provider Agreement) and an official notice of discontinuation of services must be issued.

1. The ISC/CM, Regional Office and legally responsible person shall work together to locate an alternative service provider for the person within sixty (60) calendar days of the issuance of the written notice.

2. Timeframes for completion of the transition must be developed as part of the plan and the Regional Office must be notified as soon as there is recognition that the transition cannot be accomplished by the original target date.

3. If this transition cannot be accomplished within that sixty (60) calendar day timeframe, the COS shall meet as soon as possible prior to expiration of the sixty (60) day timeframe to identify and address barriers to the transition. This meeting shall include a representative from the Regional Office.

4. The COS and the Regional Office are responsible to ensure that the transition occurs as soon as possible while simultaneously ensuring the person's health and welfare.

D. **Transition of Residence or Residential services**: If a person receiving residential services is transitioning from one residential service provider to another but staying in the current home; moving to a different residential home with the same provider; or to a different residential home with a different provider, the following procedures shall apply:

1. The COS shall ensure that the person is aware of and agrees with the transition even if the person has a conservator.

    a. If the transition has been precipitated by a **dispute** between the person supported and/or legal representative and the provider agency, the ISC/CM shall inform the DIDD complaint coordinator or Regional Office.

    b. A meeting shall be held with the person, family, conservator, and the current service provider to discuss and attempt to resolve any concerns regarding current services. This meeting shall include a representative from the regional office.

    c. If these concerns cannot be resolved, the reasons must be thoroughly documented by the ICS/CM and submitted by the ISC/CM to the Regional Office as part of the transition packet.

2. The Transition Planning Form shall be completed by the ISC/CM.

3. Requirements regarding a change in providers as written in Policy P-008-B Personal Funds Management Policy Section E.3. (h) shall be completed, as applicable. A personal budget shall be submitted indicating that the person supported can afford the on-going expenses associated with daily living in the new home. The COS shall determine how moving expenses will be funded. This shall be documented on the Transition Planning Form.

4. All necessary equipment and medication shall be present and ready for use at the new location on the day of the move.

5. The ISC/CM shall decide if a professional assessment of the person's mobility is required in order to determine the need for environmental modifications to the home. The person's occupational therapist (OT), physical therapist (PT), other appropriate professional, or department therapeutic services staff may perform the professional assessment of the person's mobility.

6. If environmental modifications are needed in order to safely support the person in the home, a site assessment of the home shall be performed. If the COS has questions concerning the need for a site assessment, the COS and/or residential provider may contact the regional therapeutic services team, or a DIDD contracted PT or OT for consultation.

7. All environmental modifications determined to be necessary for accessibility and safety shall be in place and determined to be functional by the evaluating clinician (e.g., OT or PT) prior to the move unless otherwise indicated in writing by the clinician.

8. If environmental modifications cannot be completed prior to the actual move, a plan with timeframes for completion and for ensuring the person receives needed services and care shall be submitted to the Regional Office CTC as part of the transition packet. The plan must include a target date for completion of the modifications. The ISC/CM shall notify the Regional Office CTC when the modifications are completed.

9. Any residence that will be occupied by a person supported must meet all applicable occupancy requirements (e.g., licensure, fire safety, etc.) in accordance with DIDD Provider Manual Chapter on Residential Services prior to transition to the new residence.

10. A person supported shall remain in a rented or leased residence until the terms of rental agreement or lease have been met. This requirement may be waived when:

    a. The provider agency initiating the transition is willing to accept responsibility for the payment of the remainder of the lease.

    b. The person supported has made arrangements for the payment of the remainder of the lease. If this arrangement involves an advance from a provider, there must be an approved agreement in place as required in P-008-B Personal Funds Management Policy.

    c. The person supported has received a notice of eviction.

    d. The lessor (e.g., landlord) is in default of the lease or rental agreement per Tenn. Code Ann. 47-2A-508.

11. The sending and receiving service providers shall complete the applicable section of the *Day of Move Notification of Community Transition* form and submit it to the Regional Office CTC by the first business day after the move.

12. If there is a change in residence, the ISC will ensure the next monthly visit occurs in the person's new home.

E. **Transition of Independent Support Coordination Agencies**

1. A person in services or the person's guardian/conservator may request a change in support coordination providers through the current ISC or by contacting the DIDD Regional Office.

2. A list of all support coordination providers shall be made available to the person and/or the guardian/conservator.

3. The DIDD Regional Office staff will work with the person supported and/or conservator to select a new ISC provider.

4. Before the transition is approved, the Regional Office shall receive documentation that the change is in the best interests of the person supported. No transition will be approved without such documentation.

5. The DIDD Regional Office shall notify the current as well as the new support coordination provider within seven (7) business days of approving the transition.

6. The transition shall be effective on the first day of the calendar month following approval of the transition.

7. The new ISC provider shall amend the ISP including Section C to reflect the new provider of support coordination services.

8. The transferring support coordination provider shall provide copies of the person's records to the new support coordination provider in accordance with Section A. 19 (a)(iv) of the provider agreement.

F. **Change in Personal Assistance or Day Providers**

1. The ISC/CM shall complete the transition packet and submit it to the Regional Office CTC.

2. Before any change is approved, the Regional Office must have documentation that the change is in the best interests of the person. No change shall be approved without such documentation.

3. Prior to initiation of personal assistance services rendered in a private home, the DIDD contracted provider shall conduct an inspection of the home to ensure the person's health, safety and welfare can be maintained while receiving services within the designated environment.

4. If the provider determines that the person supported cannot be safely supported in the designated home, then the provider shall notify the Regional Office CTC and the ISC/CM within one (1) business day. The ISC/CM and CTC will assist the person supported with identifying alternate service options.

G. **Inter-region Transitions**

1. When a person is transitioning from one grand region to another, the current ISC/CM shall notify the current region's CTC as soon as possible of the intended move.

2. The current CTC shall work with the CTC in the region of the anticipated move, the person supported, current ISC/CM, and COS to ensure an effective, efficient and person-centered planning process for the transition.

3. The current ISC/CM shall submit a transition plan for approval to the current CTC in accordance with this policy.

4. The current CTC shall review the transition plan and shall approve services according to service and rate approval protocols. The CTC shall ensure that all requirements in P-008-B Personal Funds Management Policy Section E.2.h have been met.

5. The person supported may choose to remain with the current ISC agency or if the current ISC agency is not operating in the region of the anticipated move, the person may choose a new ISC agency.

6. If an ISC agency in the region of the anticipated move has not been chosen, the current CTC shall work with the person and legal representative to select a new ISC agency.

7. The new ISC/CM will work with the person and legal representative to identify service providers in the region of the anticipated move.

8. The current CTC and the current ISC/CM are responsible for ensuring that copies of the person's records including cost plan information, ISP and other documents are forwarded to the CTC in the region of the anticipated move in accordance with Section A. 19 of the Provider Agreement.

9. The CTC of the current region is responsible for ending services in that region upon completion of the transition.

VII. ATTACHMENTS

A. Transition Planning Form

B. Day of the Move Notice